Young Harris COLLEGE
EST. 1886

CONFIDENTIAL HEALTH HISTORY

Counseling and Psychological Services
P.O. Box 23
Young Harris, GA 30582
Phone 706-379-5057
Fax 706-379-4318

Name _____
LAST FIRST MIDDLE

Birthdate ____/____/____ Gender _____ Semester/year entering YHC _____

Home Address _____

City, State, Zip _____

Home Phone (____) _____ Student's Cell Phone (____) _____

Home Physician _____ Phone (____) _____

Address _____

EMERGENCY CONTACTS (List 2)

First contact should be a parent, legal guardian or spouse and second contact should be someone who would know how to get in touch with contact #1 or who also has legal authority to make medical decisions for the student.

1. Name _____ Relationship _____

   Address _____

   Work # (____) _____ Home # (____) _____ Cell Phone # (____) _____

2. Name _____ Relationship _____

   Address _____

   Work # (____) _____ Home # (____) _____ Cell Phone # (____) _____

ACKNOWLEDGEMENT AND AUTHORIZATION BY STUDENT AND/OR PARENT/GUARDIAN

All information given on this form is true to the best of my knowledge and I have no abnormality, limitation, or restriction not mentioned in this record. I agree to notify Counseling and Psychological Services of any change that may occur, whether such change occurs prior to my registration or while I am a student.

I understand that my counseling records are confidential. To have my records shared with others requires my written permission except if there is evidence of clear and imminent danger of harm to self or others; in which case, a counselor is legally required to report this to the appropriate persons in order to ensure safety.

PERMISSION is hereby granted to the Counseling and Psychological Service staff for treatment of this student.

_____
Signature of Student *Date* *Signature of Parent/Guardian*

Medication Allergies (write NONE if none)	Food/Environmental Allergies	Current Medications (include dosage)

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM

Difficulty with:	Now	Past
Anxiety		
Depression		
Mood Changes		
Anger or Temper		
Panic		
Fears		
Irritability		
Concentration		
Headaches		
Loss of Memory		
Excessive Worry		
Feeling Manic		
Trusting Others		
Communicating with others		
Drugs		
Alcohol		
Caffeine		
Frequent Vomiting		
Eating Problems		
Severe weight gain		
Severe weight loss		
Blackouts		

Difficulty with:	Now	Past
People in general		
Parents		
Children		
Marriage/Partnership		
Friend(s)		
Co-Worker(s)		
Employer		
Finances		
Legal Problems		
Sexual Concerns		
History of child abuse		
History of sexual abuse		
Domestic Violence		
Thoughts of hurting someone else		
Hurting Self		
Thoughts of suicide		
Sleeping too much		
Sleeping too little		
Getting to sleep		
Waking too early		
Nightmares		
Head injury		

Difficulty with:	Now	Past
Nausea		
Abdominal Distress		
Fainting		
Dizziness		
Diarrhea		
Shortness of Breath		
Chest Pain		
Lump in the throat		
Sweating		
Heart papitations		
Muscle tension		
Pain in joints		
Allergies		
Often make careless mistakes		
Fidget frequently		
Speak without thinking		
Waiting your turn		
Completing tasks		
Paying attention		
Easily distracted by noises		
Hyperactivity		
Chills or hot flashes		

Family History of (Check all that apply)			
Drug/Alcohol Problems			
Legal trouble			
Domestic violence			
Suicide			

Physical abuse	
Sexual abuse	
Hyperactivity	
Learning diabilities	

Depression	
Anxiety	
Psychiatric hospitalization	
Nervous breakdown	

Any additional information you would like to include:

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Student Name _____

Date of Birth _____

CERTIFICATE OF IMMUNIZATION (Required for enrollment)

REQUIRED IMMUNIZATIONS	REQUIREMENT	REQUIRED FOR:
MMR (Measles, Mumps, Rubella) combined shot	•2 Doses #1 ____/____/____ #2 ____/____/____	• All students born in 1957 or later
---------- OR ----------	---------- OR ----------	----------
• **Measles (Rubeola)**	•2 Doses #1 ____/____/____ #2 ____/____/____	• All students born in 1957 or later
and	• **or** Titer ____/____/____	
	and	
• **Mumps**	2 Doses #1 ____/____/____ #2 ____/____/____	• All students born in 1957 or later
and	• **or** Titer ____/____/____	
	and	
• **Rubella (German Measles)**	2 Doses #1 ____/____/____ #2 ____/____/____	• All students attach titer results if done
	• **or** Titer ____/____/____	
Varicella (Chicken Pox)	2 Doses #1 ____/____/____ #2 ____/____/____	• All U.S. born students born in 1980 or later and all foreign born students regardless of year born
	• **or** History of chicken pox or shingles ____/____/____	
Self/parental reported history of disease not accepted.	• **or** Titer ____/____/____	• Attach titer results if done
Tetanus and Diphtheria (Td or Tdap)	Td ____/____/____ • **or** Tdap ____/____/____	• All students must have one dose within 10 years

OPTIONAL IMMUNIZATIONS			
Hepatitis A 2 doses	# 1 ____/____/____	#2 ____/____/____	
Hepatitis B 3 doses	# 1 ____/____/____	#2 ____/____/____	#3 ____/____/____
Meningitis (Menactra or Menveo)	# 1 ____/____/____	#2 ____/____/____	(if 1st dose more than 5 yrs prior to admittance)
Gardasil 3 doses	# 1 ____/____/____	#2 ____/____/____	#3 ____/____/____

REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY

Name _____ Address _____

Signature _____ _____

Date _____ Phone _____